

Parker Healthcare Management Organization, Inc.

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DATE OF REVIEW: JULY 2, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Lumbar ESI L5-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on X/XX/XX, in a motor vehicle accident. The claimant was diagnosed with a sprain of the ligaments of the lumbar spine. An MRI of the lumbar spine on X/X/XX, documented an L5-S1 central, left greater than right, paracentral, disc extrusion that was a 2 mm, anterior to posterior, 9 mm left to right, and 4 mm superior to inferior. There was 25% central canal stenosis and contact of both S1 nerve roots. Electrodiagnostic studies on X/X/XX, documented no evidence of lumbosacral radiculopathy. An evaluation on XX/XX/XX, documented back pain of 8/10 on a Visual Analog Scale. The lumbar spine had range of motion that was decreased in all planes. There were muscle spasms in the paraspinal musculature. Deep tendon reflexes were normal and sensation was normal as was motor strength. Straight leg raise testing was negative bilaterally. The gait was normal. An epidural steroid injection was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDELINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines, radiculopathy should be documented on physical examination and corroborated on imaging studies and/or electrodiagnostic testing with initial unresponsiveness to lower levels of care. The imaging reported contact of the bilateral S1 nerve roots at L5-S1 however electrodiagnostic studies did not note radiculopathy. Records do not reflect any conservative care as required other than the use of oral medications. The most recent physical therapy note was from October 2015 and noted some improvement with therapy at that time. There were no more recent physical therapy notes to indicate current care or continuation of a home exercise program. Radiculopathy was not noted on physical examination. Therefore, the request for an L5-S1 epidural steroid injection is not certified as medically necessary.

Official Disability Guidelines Low Back (updated 05/09/16) Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. (1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, muscle relaxants & neuropathic drugs).

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN
ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES